

### ACH VENDOR AUTHORIZATION



SECTION 1	Please complete Sections 2 and 3 below; your financial institution <u>must</u> complete Section 4 prior to returning the form to AHCCCSA.			
	New ACH Setup _____	Change Account Type _____	Change Account Number _____	Change Financial Institution _____
	If you are requesting a <i>Cancellation</i> , please check the box below and complete Section 2, 3, and 5			
	Cancellation Request _____			

PAYEE IDENTIFICATION	
1. Federal Employer's Identification Number (EIN) I _ I _ I - I _ I _ I I I I I I I I	Disclosure of your social security number is voluntary pursuant to 42 U.S.C. 405(c)(2)(C).* The State of Arizona will use your SSN or EIN to file required information returns with the Internal Revenue Service.
Or Social Security Number (SSN) I _ I _ I _ I - I _ I _ I - I _ I _ I I I I	
AHCCCS Provider Number and Locator Code: _____ <b>This must be complete or request may be denied.</b>	
2. _____ Payee's Name (Provider)	3. ( _ I _ I _ )-I _ I _ I I I-I _ I _ I I I I I I Business Phone (Area code and number)
4. _____ Address	5. _____ City
_____	_____ I _ I _ I I I I I-I _ I _ I I I I I I State Zip Code

<b>SECTION 3</b>	<p><b>AUTHORIZATION FOR SETUP, CHANGES, OR CANCELLATION</b></p> <p><b>6.</b> I authorize the Arizona Health Care Cost Containment System (AHCCCSA) to process payments owed to me via Automated Clearing House (ACH) deposits. AHCCCSA shall deposit the ACH payments in the financial institution and account designated below.</p> <p><b>* I recognize that if I fail to provide complete and accurate information</b> on this authorization form, the processing of the form may be delayed or made impossible, or my electronic payments may be erroneously made.</p> <p><u>I authorize AHCCCSA to withdraw from the designated account all amounts deposited electronically in error.</u> If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize AHCCCSA to withhold payment owed to me by them until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to AHCCCSA, Attn: Finance Dept., Mail Drop 5400. The change or revocation is effective on the day that AHCCCS processes the request.</p> <p>I certify that I have read and agree to comply with AHCCCSA's rules governing payments and electronic transfers as they exist on the date of my signature on this form or as subsequently adopted, amended, or repealed. I consent to, and agree to, comply with these rules even if they conflict with this authorization form.</p> <p>I authorize AHCCCSA to stop making electronic transfers to my account without advance notice.</p> <p>I certify that I am authorized to contract for the entity receiving deposits, pursuant to this agreement, and that all information provided is accurate.</p> <p><b>The financial institution can process CTX payments/transactions along with addendum information.      Yes _____ No _____</b></p>			
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 35%; padding: 5px;"><b>7. Signature (Required)</b></td> <td style="width: 35%; padding: 5px;"><b>8. Title:</b></td> <td style="width: 30%; padding: 5px;"><b>9. Date</b></td> </tr> </table>	<b>7. Signature (Required)</b>	<b>8. Title:</b>	<b>9. Date</b>
<b>7. Signature (Required)</b>	<b>8. Title:</b>	<b>9. Date</b>		

FINANCIAL INSTITUTION (Must be completed by financial institution representative.)	
10. Bank Name: _____	
11. Bank Address: _____	12. City: _____ State: _____ Zip Code: I _ I _ I _ I _ I _ I _ I _ I _ I _
13. Routing transit number: I _ I _ I _ I _ I _ I _ I _ I _ I _	14. Customer account number: I _ I _ I _ I _ I _ I _ I _ I _ I _ I _ I _ I _ I _ I _ I _
15. Type of account: <b>Checking</b> _____ <b>Savings</b> _____	
16. _____ Financial institution representative name (Please print):	17. _____ Title:
18. ( _ I _ I _ ) - I _ I _ I _ I _ I _ I _ I _ Phone (Area code and number):	
19. Signature (Required) _____	20. Date: _____

SECTION 5	<b>CANCELLATION</b>	
	21. Reason:	22. Date:

SECTION 6		AHCCCSA USE ONLY	
23.	Provider information verified by: _____	Does Provider have aged invoice balance? Yes _____	Amount \$ _____ No _____
24.	Provider ACH Approved by: _____	Effective begin date: _____	
25.	Comments: _____		
COMPLETED BY _____		DATED _____	